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WOMEN WITH ALCOHOL PROBLEMS SEEKING TREATMENT

Underlying individual and psychosocial
characteristics

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ABSTRACT

The consequences of hazardous or harmful alcohol use are both physiological and psychosocial and seem to occur earlier in the use of alcohol for women as compared to men. Seeking treatment for alcohol problems means crossing a threshold; this is especially the case for women who perceive that having an alcohol problem is not compatible with female gender expectations. In the present thesis the complete data sets of 134 women, consecutively seeking treatment during 2001 – 2005 at a Swedish clinic specialized in women with alcohol problems, were studied. Almost all women fulfilled the criteria of a DSM-IV diagnosis of alcohol dependence. The main aims were to explore the women's underlying individual and psychosocial characteristics within a Swedish context, and to examine factors influencing treatment outcomes.

In **study I** we performed a qualitative analysis of data from case journals in order to examine the cultural meanings associated with women with alcohol problems and their seeking treatment for these problems. The findings stressed that cultural factors are of importance for understanding this population, for example they perceived a negative Swedish cultural identity status in relation to their problem drinking. In **study II** we investigated moods and expectancies before a typical drinking occasion in relation to perceived relations to parents. The findings indicated that the women had expectations of a mood change when drinking and primarily negative feelings, which they wanted to change by drinking. Their perceived relation to parents was positive for only 12% of the women and it was found that a perceived negative relation to mother significantly influenced the amount of drinking in the direction of increased drinking at the end of treatment. In **study III** factors related to treatment approaches and outcomes for two different samples of problem-drinking women, Swedish and North American, were contrasted. The findings indicated that having the opportunity to receive any type of alcohol treatment is utterly important for reducing harmful drinking to a non-risky level. **Study IV** investigated whether personality and perceived health characteristics could be of importance for treatment planning. Two clusters were identified. Women in Cluster 1 perceived themselves as having severe psychological health problems, and rated different aspects of their personality deviant from mean norm scores. In Cluster 2 the women perceived better psychological health and had a personality profile within mean norm scores. The women in the clusters differed in treatment utilization: with Cluster 1 having a significantly higher treatment visit rate than those in Cluster 2. Both clusters significantly decreased their drinking; yet there were no differences between the clusters related to decreased alcohol consumption at the end of treatment.

In conclusion, the present women with alcohol problems seeking treatment had severe alcohol problems, though they were relatively well-functioning socially. Taken as a group, these women were found to be heterogenic in terms of personality dimensions and perceived self-rated psychological health. Most of them were brought up with one or both parents having alcohol problems and had a relation to their parents influencing their own drinking and treatment outcome, in a negative way. However, availing themselves of treatment helped the women as a group to reduce their drinking.

LIST OF PUBLICATIONS

- I. DeMarinis V., Scheffel-Birath C., & Hansagi H. Cultural Analysis as a Perspective for Gender-Informed Alcohol Treatment Research in a Swedish Context. *Alcohol & Alcoholism* 2009 November-December; 44(6):615-619.
- II. Scheffel Birath C., DeMarinis V., & af Klinteberg B. Moods and expectancies of female alcohol drinking – an exploratory study. *Scandinavian Journal of Caring Sciences*, 2009, in press.
- III. Scheffel Birath C., af Klinteberg B., DeMarinis V., Hauke S., Jones JA., & Chang G. Treatment outcomes for risk drinking women: Brief and long term approaches. *Manuscript submitted*.
- IV. Scheffel Birath C., DeMarinis V., Stenbacka M., & af Klinteberg B. Women with alcohol problems – the possible significance of personality clustering for treatment planning. *Manuscript submitted*.

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LIST OF ABBREVIATIONS

AVI-R	Alkoholvaneinventoriet - reviderad (Alcohol Use Inventory – revised)
BI	Brief Intervention
CARE	The Consultation and Relational Empathy measure
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fourth ed.
FU	Follow up
MI	Motivational Interviewing
KSP	Karolinska Personality Scales
PSS	Perceived Stress Scale
RTCQ	The Readiness To Change Questionnaire
SBU	Statens Beredning för Medicinsk Utvärdering [The Swedish Council on Technology Assessment in Health Care]
SSP	Swedish Universities Scales of Personality
TLFB	Time-Line-Follow-Back

1 INTRODUCTION

The work in this thesis has focused on treatment-seeking women with alcohol problems. The main aims were to explore the women's underlying individual and psychosocial characteristics within a Swedish context, and to examine factors influencing treatment outcomes.

1.1 BACKGROUND

Health consequences due to alcohol use form one of the largest category of causes affecting disability adjusted life years (DALYs) in Western societies according to the WHO (WHO, 2002). In developed countries about 9% of all DALYs are attributed to alcohol. The alcohol drinking patterns among the Swedish population have undergone a dramatic change during the last 50 years. About a half decade ago the Bratt's system of rations for alcohol was terminated. Since the First World War this system allowed each individual to buy only a certain amount of distilled spirits per month (Norström, 2002). According to the system it was possible to control individuals through different allotments. Unmarried women were permitted to buy less alcohol than young adult males, and married women were not given any allocations at all as they were expected to share their husband's allocation, usually about four litres per month (Norström, 2002). The possibility for women to develop an alcohol drinking problem during this period was obviously very restricted.

It remains so that men drink more than women do, in fact twice as much (Andreasson & Allebeck, 2005). The prevalence rate for alcohol abuse among men is estimated to be 5 – 20%, and among women 1.5 – 8%, depending on age and socioeconomic grouping (Allebeck *et al.*, 2001; Nolen-Hoeksema, 2004). However, women's consumption and drinking patterns have gradually changed (Ahlstrom, *et al.*, 2001). The increase in alcohol consumption is today higher among women than men, and the biggest increase is seen among women at or over the age of 50 (Andreasson & Allebeck, 2005). The proportion of self-reported high-consumers has been more than doubled between 1990 and 2002 for women (1.9 to 4.7), the same proportion mentioned among men has also increased (5.6 to 8.3) (Andreasson & Allebeck, 2005). In grams alcohol the Swedish women consumed 1 1/3 bottle of wine/week (1 bottle of wine corresponds to approximately 70 gr. alcohol), but only about 30 percent of the women were drinking more than the mean, and about 1/10 of the consumers were estimated to drink half of the total consumed alcohol (Andreasson & Allebeck, 2005). These are the individuals that most certainly come to treatment sooner or later.

The cultural background influencing the societal alcohol policy during the 20th century, understanding alcoholism as mostly caused by a genetic weakness has now been abandoned. The development of alcohol problems today is generally understood as a multi-factorial disease process that involves a complex interaction of: exposure to alcohol, biological (genetic and developmental), and environmental factors (social, psychological and cultural vulnerability) (Volkow & Li, 2005). In this thesis the focus will be psychosocial environmental factors, such as personality, drinking expectations, and self-rated health, situated within Swedish cultural and gender analyses.

1.2 ALCOHOL DIAGNOSES

Most adult Swedish people today use alcohol. Abstainers are most frequent in the category of adults above 65 years (Boström, 2003). An alcohol consumption that is considered safe is very low for both men and women. No exact limits for safe drinking can be set, but reported health benefits for men over 70 years old is slightly less than one standard drink per day, and for women at the same age less than half a standard drink per day. People younger than 40 years old have no reported health benefits from drinking alcohol (Andreasson & Allebeck, 2005). Drinking more than 5 standard drinks of alcohol per week (98 gr. alcohol) has been defined as risky drinking according to The International Centre for Alcohol Policies (ICAP) (ICAP, 1998). Engaging in risk-filled drinking during a period of life does not automatically mean that someone will fulfil the diagnostic criteria for *alcohol abuse* or *alcohol dependence*. However, the longer the duration of a period, often in combination with both psychosocial environmental and biological factors, the greater the probability of developing an alcohol diagnosis. The age for debut of drinking is seen as the most important factor for developing later alcohol problems (Spak *et al.*, 1997; Pedersen & Skrandal, 1998). It was also found that young people's drinking patterns resemble those of their parents and that the influence of parents' drinking norms had an effect on the debut age in girls (Pedersen & Skrandal, 1998). Growing up with parents having an alcohol problem was found to be common among women with alcohol problems (DeMarinis *et al.*, 2009; Scheffel-Birath *et al.*, 2009a). This fact was often connected to negative feelings towards the parents and a sense of being raised with a lot of stressors (DeMarinis *et al.*, 2009; Scheffel-Birath *et al.*, 2009a). According to the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (American Psychiatric Association, 2000) a harmful use diagnosis is defined as a use of alcohol leading to one or more problems of social/and of personal nature for the individual including recurrent use resulting in: failure to fulfil major roles at work, in school or at home; repeated alcohol-related legal problems; alcohol use in situations physiologically hazardous; and/or, continuing use despite having problems exacerbated by the effects of alcohol. Alcohol dependence is a more serious diagnosis with several physiological and psychological consequences of drinking. The criteria for alcohol dependence according to DSM-IV are described in Table 1.

Table 1. DSM-IV Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following
 - a. A need for markedly increased amounts of the substance to achieve intoxication or the desired effect
 - b. Markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following
 - a. The characteristic withdrawal syndrome for the substance
 - b. The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
6. Important social, occupational, or recreational activities are given up or reduced because of substance use
7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance

1.3 WOMEN'S DRINKING AND TREATMENT

Women as a group drink less alcohol and have fewer alcohol-related problems than men (Nolen-Hoeksema, 2004). There are certain protective factors against alcohol problems for women. Historically, women had restrictions when both buying and drinking alcohol (Norström, 2002), current restrictions are pregnancy and breast-feeding, where adverse results of alcohol use are well (Andreasson & Allebeck, 2005). However, women's alcohol consumption has increased over the last decades and their alcohol drinking patterns have become more similar to men's (Bergman & Kallmen, 2003), and studies show that extensive alcohol use during pregnancy today is a problem in the Swedish society (Goransson *et al.*, 2003). The prevalence for women of hazardous or harmful alcohol use had increased during the 1990^s, particularly among 16 – 29 years old and 50 – 75 years old (Leifman & Trollidal, 2001; Bergman & Kallmen, 2003). Harmful consequences of alcohol drinking occur at lower doses for women as compared to men, and include: liver cirrhosis, cardiac diseases, reduced fertility, and decreased cognitive and motor performance (Nolen-Hoeksema, 2004). This sex difference happens because of a higher blood alcohol level in women as compared to men for a given dose of alcohol since women generally are smaller, have less body water, and a different metabolism of alcohol (Nolen-Hoeksema, 2004).

The need for treatment options specialized for women has been observed in line with increased consumption (Haver & Franck, 1997). In Sweden the first clinic focused on women's alcohol problems was started in 1980 at the Karolinska Hospital in Stockholm, the EWA-clinic (Early Treatment of Women with Alcohol Addiction) (Dahlgren & Wistrom, 1985). The target group then was women that had never sought treatment.

Today, most of the bigger cities in Sweden offer treatment for women with substance abuse problems at a special women's unit.

1.3.1 Psychosocial treatment options

Assessing what works and why are central issues when discussing different treatment options (Project Match Research Group, 1998; Read *et al.*, 2001; Miller & Wilbourne, 2002; Kaner *et al.*, 2007). In 2002 a meta-analysis from Statens Beredning för Medicinsk Utvärdering [The Swedish Council on Technology Assessment in Health Care] (SBU) was presented (Statens beredning för medicinsk utvärdering, 2001). However, most studies included in the meta-analysis were performed on male subjects that outlined a number of evidence-based treatment options for alcohol problems (Statens beredning för medicinsk utvärdering, 2001). In 2007 The Swedish National Board of Health and Welfare (Socialstyrelsen) presented the guidelines for the treatment of alcohol dependence (Socialstyrelsen, 2007). Regarding current psychosocial treatment methods, the recommendations from the National Board emphasize specific methods with focus on alcohol problems. Further, they conclude that there is support for matching intensity in treatment to severity of the alcohol problem (Socialstyrelsen, 2007). It seems that there does not exist "only one way to sobriety"-method. The most commonly used clinical methods for treating alcohol problems are: motivational interviewing/enhancement treatment (MI) (Miller & Rollnick, 2002); cognitive-behavioural therapies (CBT) including skills training and relapse prevention (Marlatt & Gordon, 1985; Saxon & Wirbing, 2004); 12-step treatment (according to Anonymous Alcoholics) (Project Match Research Group, 1998); brief intervention (BI) (Kaner *et al.*, 2007); supportive counselling (Project Match Research Group, 1998); psychotherapy (both dynamic and interactional) (Statens beredning för medicinsk utvärdering, 2001); and, family therapy (Winters *et al.*, 2002).

A description of the psychosocial treatment methods used in the clinic where data were collected for the studies included in this thesis is presented below.

1.3.1.1 MI

Motivational interviewing or enhancement is a client-centred model, usually defined by FRAMES meaning Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy (Rollnick *et al.*, 1992; Miller & Rollnick, 2002). In MI the patient is encouraged to explore, in a non-threatening environment, his or her drinking and its consequences. The therapist works with open-ended questions, reflective listening, and is supposed to avoid argumentation. MI has strong evidence of treatment efficacy (Project Match Research Group, 1998; Read *et al.*, 2001).

1.3.1.2 BI

BI-interventions are often a mix of MI and a medical examination and are mainly used as an intervention for early identification among problem drinkers (Kaner *et al.*, 2007).

Commonly BI-interventions use MI style and techniques that are incorporated into a time-limited, health-care context format (Vasilaki *et al.*, 2006).

1.3.1.3 Family therapy

Interventions involving spouse and/or other family members in the patient's treatment are often summarized as family therapy. The family therapy can be theoretically grounded in psychodynamic, cognitive-behavioural, transactional or 12-Step methods. In the meta-analysis from SBU (Statens beredning för medicinsk utvärdering, 2001) family therapy had better results for decreased alcohol consumption when compared to individual treatment, but no significance was found for distinguishing among specific family therapy theories (Statens beredning för medicinsk utvärdering, 2001).

1.3.1.4 Relapse prevention

Relapse prevention is a cognitive-behavioural therapy focusing on mapping risk situations for relapses and skill-enhancement strategies for coping with risk situations. This enhances self-efficacy for the handling of alcohol craving and for responding to situations where alcohol is involved (Marlatt, 1985). Relapse prevention can be administered both in individual- and in group treatment. Relapse prevention has been shown to have positive effects for heavy drinkers after 6- but not 12-month post-treatment assessments (Irvin *et al.*, 1999; Statens beredning för medicinsk utvärdering, 2001).

1.4 THEORETICAL FRAMEWORK

When attempting to gain an understanding of individual and psychosocial characteristics among women with alcohol problems, a number of areas need to be covered. A description of women with alcohol problems can be given by providing mean average terms, indicating how this group of women thinks, feels, behaves or reacts to for example treatment methods. This information can be of importance for decisions in a clinic specialized in treatment methods for alcohol problems. However, a mean average just tells us a small part about the included individuals. Several factors are involved in complex interactions when an individual develops the specific pattern that constitutes an alcohol problem. These include among others: gender factors (Cloninger *et al.*, 1988; Ahlstrom *et al.*, 2001), genetic factors (Bohman *et al.*, 1987; Kendler *et al.*, 1994), cultural or societal factors (Kearney, 1997; Room, 2001), relational factors (Brown *et al.*, 1987; Bogart *et al.*, 1995; Conway *et al.*, 2003), and personality factors (Brown *et al.*, 1980; Carey & DiLalla, 1994; Bergman *et al.*, 1998).

In this thesis the most striking factors are aspects of the personality and the consequences that a certain disposition can have on increased vulnerability to alcohol problems as well as the consequences it can bring to handling every-day stressors and more specific life problems.

1.5 PERSONALITY

Personality can be defined in different ways, all of us use the concept to describe and understand how persons think and behave (McCrae & Costa, 1989). The personality of a person is found to be rather stable during the lifespan. The origin of personality is most often seen as a complex process involving genetic predispositions, reinforcements from inner and outer environments, experiences, and interpersonal relationships (Watson *et al.*, 1994). Personality as a wide expression refers to those characteristics of a person that form a consistent and dynamic pattern representing habits, traits, styles, presence of states, feelings, thoughts and behaviours (Exner, 1986; Pervin & John, 2000). The role of cultural influences when understanding the development of personality must be taken into consideration when understanding psychopathology (Lewis-Fernandez & Kleinman, 1994). Cultural influence can also enhance certain personality features that are expected in a given cultural context during a specific time period indicating, for example, that a woman should be first a mother, second a partner, and after that take care of her personal needs (DeMarinis *et al.*, 2009).

Personality traits are supposed to mirror underlying individual characteristics whether genetic or psychosocial, as manifested in daily behaviour. Personality traits emerge from patterns of these characteristics and have been used extensively in psychology and psychiatry when assessing psychopathologies (Watson *et al.*, 1994). There are different theories of how certain factors can influence the development of a psychopathology. One theory that has had great influence in clinical psychology is attachment theory, emphasizing the early bonds between the small child and the caregiver. Attachment theory is a framework for understanding the interpersonal part of the concept of personality (Bowlby, 1944). The optimal development according to this theory is a secure attachment style, which will be the ground for the development of cognitive, affective and behavioural traits during the lifespan. Experiences of trauma or persisting stress can influence a change from a secure attachment style to one of a more avoidant or anxious nature (Bowlby, 1944). Biological theory stresses the genetic influence on the development of personality and states that our genes account for between 30% and 60% of the variance on our adult personality traits (Carey & DiLalla, 1994).

1.5.1 Personality assessment

Assessing personality traits has a long tradition mostly done by letting the person rate a number of operationalized items concerning his/her view of oneself. Assessment of personality traits could be performed through tools with a biological framework (Eysenck & Eysenck, 1985; Schalling *et al.*, 1987; Gustavsson *et al.*, 2000) or through a lexical and atheoretical model (Costa & McCrae, 1997; Digman, 1997). Assessment formulas developed from a biological approach are for example the Karolinska Scales of Personality (KSP) (Schalling *et al.*, 1987), a scale for investigating both healthy subjects and psychiatric patients (Gustavsson *et al.*, 2000). A revised and shortened version of KSP is the Swedish Universities Scales of Personality (SSP) (Gustavsson *et al.*, 2000). It consists of 91 items in 13 scales. The SSP, through factor analysis, identified personality traits in three factors: Neuroticism, Aggressiveness and Extraversion (Gustavsson *et al.*, 2000). Another widely spread method in assessing personality traits is using a factor analytic model resulting in a five-factor model of

personality (Digman, 1997). The five-factor model of personality, called The Big Five, is a representation of the structure of personality traits (Costa & McCrae, 1997). In this thesis the SSP was used as an instrument for assessing personality traits to mirror individual differences among the women investigated.

1.6 ALCOHOL-RELATED HEALTH PROBLEMS

Health problems, both psychological and physiological, are often related to alcohol problems. Compared to men, women who drink alcohol are more vulnerable to its negative effects, including psychological and physiological consequences (Andreasson & Allebeck, 2005).

1.6.1 Psychological health

The vulnerability to psychological consequences of alcohol drinking includes increased incidence of lifetime and current psychiatric symptoms including depression, anxiety, burn-out syndrome, and suicide ideation (Andreasson & Allebeck, 2005; Berglund *et al.*, 2008). Alcohol abuse worsens the course of psychiatric disorders for both men and women, and about one-fifth to one-third of increased death-rate among alcoholics is explained by suicide (Berglund & Ojehagen, 1998). Interpersonal loss within six weeks before suicide is more often present among alcoholics than nonalcoholic suicide victims (Berglund & Ojehagen, 1998). The comorbidity for alcohol use disorders and major depression are more pronounced among women as compared to men (Nolen-Hoeksema, 2004), and women with substance abuse problems have lower levels of self-esteem and higher levels of anxiety than men (Kohn *et al.*, 2002). Consequences of having an alcohol problem causes problems with interpersonal relations, self-esteem, and social sanctions against drinking women (Nolen-Hoeksema, 2004).

1.6.2 Physiological health

There are a number of diseases exacerbated by alcohol consumption. The most common medical conditions caused by drinking are: hypertension (Fuchs *et al.*, 2001), diabetes (Diem *et al.*, 2003), osteoporosis (Felson *et al.*, 1995), and infertility (Grodstein *et al.*, 1994). Increased risks are also found, in connection to high alcohol consumption, for heart- pancreas- and liver diseases, cancer, and physical harm due to accidents (Andreasson & Allebeck 2005). For women it is found that as little as one daily drink (15 cl of wine) may increase the risk of breast cancer (National Institute of Health, 2000).

1.6.3 Assessment of health variables

Health can be measured as medical health/illness or perceived health/illness. Medical examinations can be used when assessing health but are time-demanding. In surveys it is more common to use measures of subjective self-reported health for assessing health/illness. A number of health questionnaires are used for the purpose of investigating health among individuals and/or groups of individuals. Most frequently

used is the Nottingham Health Profile (Carr-Hill & Kind, 1989) and SF 36 (Jenkinson *et al.*, 1993). Both questionnaires contain a number of multi-item variables measuring physical and emotional functioning and problems. They are usually experienced as easy and quick to answer. In the studies described in this thesis an instrument called The Health Index was used. This instrument was designed for measuring patients' self-perceived psychological and physiological health during the preceding week and is built on the Nottingham Health Profile (Andreasson *et al.*, 2002) and revised to Swedish conditions at the Karolinska Institute.

1.7 MOOD STATES AND EXPECTATIONS OF DRINKING

When voluntarily drinking alcohol most people usually have a reason for their consumption. Questioning often results in answers like "it taste good", "enhancement of flavours", "it makes me feel a bit more easy". This means that we have expectations of what drinking alcohol will bring. Most people also verbalize that drinking is something you prefer to do when feeling comfortable, as "feeling satisfied when having a tasty dinner", "socializing with friends". This indicates that drinking alcohol is something you prefer to do when already feeling happy or satisfied. The motives or trigger factors for drinking alcohol are mostly connected to eating and may be a way of enhancing an already positive emotion (Marlatt, 1985). Drinking alcohol can be a way to attempt to regulate emotional experiences.

Expectancies of intoxication have been found to mediate certain behaviours like enhanced social, physical, and sexual pleasure, increase power and aggression, increase social assertiveness, and reduce of tension (Brown *et al.*, 1980). It is reasonable to state that more global positive expectations probably are related to light alcohol consumption while heavier drinking has other underlying expectations (Brown *et al.*, 1980; Brown *et al.*, 1987). It has been found that a family history of problem drinking can moderate expectations of alcohol consumption (Conway *et al.*, 2003). Having a first relative with drinking problems increases a positive global expectation of drinking effects and is also associated with increases in problem drinking symptoms (Conway *et al.*, 2003). The differentiation among different kinds of drinking expectancies, in this thesis, was done through a contextual analysis of how the women described their expectancies resulting in: enhancing a feeling, reducing a feeling or flight from feeling.

The underlying conscious mood states that are intended to change while drinking can be stated as mainly positive or negative. A definition of mood was proposed by Nowlis (Nowlis & Nowlis, 1956) as an "intervening variable or predispositional factor that is a source of information, or discriminable stimuli to the organism, about the current functioning characteristics of the organism", where conscious mood consists of the perceptual and cognitive responses to this information. A presentation of aspects of mood was presented by Sjöberg (Sjöberg *et al.*, 1979) and consists of six bipolar aspects of mood (pleasantness/ unpleasantness, activation/ deactivation, calmness/ tension, extraversion/introversion, positive/negative social orientation, and control/lack of control. The first three aspects were found to be most basic in a factor extraction model (Sjöberg *et al.*, 1979), and were used in this thesis to understand and categorize the perceived mood states expressed by the women.

1.8 GENDER

The definition of gender differs between disciplines. In medicine disciplines gender is often used denominating the biological sex (Hammarström, 2005). In social sciences the concept of gender usually has a more differentiated explanation. Gender, in this thesis, refers to the social sex and concerns what is culturally attributed to being a man or a woman in different societies (Hammarström, 2005). The society gives meaning to the fact that humans consist of two different sexes (Magnusson, 2003) and gender construction can be viewed as a dynamic and social structure which is produced and reproduced through people's actions (Courtenay, 2000). In a society gender stereotypes are characteristics that are generally believed to be typical either for a woman or a man (Courtenay, 2000). Characteristics that are given to men often refer to dominance and giving him power and control over women and children (Van Den Bergh, 1991). One gender stereotype concerning alcohol consumption is that sobriety is a sign of femininity and is not associated with masculinity (Eriksen, 1999). In many studies of treatment-seeking women with alcohol problem feelings of shame are frequently named as a primary reason for hesitating to get help for their alcohol problems (Kearney, 1997; Jakobsson *et al.*, 2008; DeMarinis *et al.*, 2009).

1.8.1 Gender-informed treatment

The fact that most individuals with alcohol problems are males means that in clinics treating alcohol problems there are more men than women. Moreover, more problems with shame and often other gender responsibilities for family and children compared to men with alcohol problems brings a treatment for women-only, when optional, attractive for many women (Dahlgren & Willander, 1989; DeMarinis *et al.*, 2009). By gender-informed treatment, in this thesis, is meant an option for treatment exclusively for women with alcohol problems, with treatment methods that focus on: building self-esteem; handling anxiety and depression; creating a safe environment for working with feelings of guilt and shame; and, supporting their responsibilities within the family (Dahlgren & Willander, 1989; Kearney, 1997; Jakobsson *et al.*, 2008; DeMarinis *et al.*, 2009). Traditional alcohol treatment usually does not include these methods.

1.9 CULTURAL ASPECTS

The concept of culture is intertwined in the manifestations of alcohol consumption, drinking patterns and conceptions of permitted use for different groups of the society (Room & Makela, 2000; DeMarinis *et al.*, 2009). Culture is here referred to as shared acquired patterns of behaviour and meaning that are constructed and transmitted within social-life contexts for the purpose of promoting individual and group survival, adaptation, and adjustment (Marsella, 2008). These shared patterns are dynamic and can become dysfunctional (Marsella, 2008). When assuming that gender is a construction formed from different cultural systems (Hess & Ferree, 1987) one can expect that both physiological and psychological factors as well as social differences between men and women can be reflected in their drinking patterns (Ahlstrom *et al.*, 2001). When using cross-cultural data it is possible to improve our understanding of factors contributing to drinking patterns and problems (Room, 2001). A sensitivity to

different social roles for men and women is important when planning for different interventions and treatment (Ahlstrom *et al.*, 2001). Such knowledge can involve special support programs for vulnerable groups.

2 AIMS

The main aims in this thesis were to explore the women's underlying individual and psychosocial characteristics within a Swedish context, and to examine factors influencing treatment outcomes.

Specific aims of the studies:

Study I

To investigate the role of culture in women's drinking at a clinic for women with alcohol problems in a Swedish treatment context.

Study II

To explore self-reported states of mood and expectancies preceding a typical drinking occasion vs. relations with parents and drinking outcome; and to investigate if vulnerability factors in terms of personality and health are related to severity of alcohol problems.

Study III

To describe and contrast treatment outcomes for two groups of women with problem drinking, and evaluate potential predictors of treatment outcome as gram alcohol per drinking day and percent of drinking days. These predictors included patient attitude towards drinking change, treatment satisfaction, and psychological stress.

Study IV

To establish individual differences in treatment outcome in terms of drinking outcomes (gram and number of drinking days); perceived health (self-rated psychological and physiological health variables); and use of treatment resources (length of time in treatment and number of visits) among 134 treatment-seeking women with alcohol problems in a clinical context, based on belongingness to one of two personality clusters.

3 MATERIALS AND METHODS

3.1 SETTINGS

The studies have taken place at an outpatient clinic, specialised for women with alcohol problems in a larger city in Sweden. The work at the clinic is focused on women of child-bearing age or having children less than 18 years old. Treatment methods at the clinic are built on knowledge from gender- and culture-informed research addressing substance abuse problems, relieving guilt and shame, and relationships through a life context approach. The treatment methods include attention to alcohol use through Motivational Interviewing (MI), Auricular acupuncture, family therapy, relapse prevention group treatment, and supportive therapy for the women's children. All members of the treatment team are women and include family therapists, nurses, a psychologist and a physician.

In study III one of the study samples came from an outpatient treatment service in a larger city in the USA. The women in this sample, being treated for other medical conditions exacerbated by alcohol, were offered a Brief Intervention (BI) for their identified risk-drinking patterns.

3.2 SAMPLES

The studies in this thesis are based on data from two projects; (i) one cohort study with data from women at a Swedish clinic specialised for treating women with alcohol problems and (ii) a subset drawn from a larger US study of risk-drinking women.

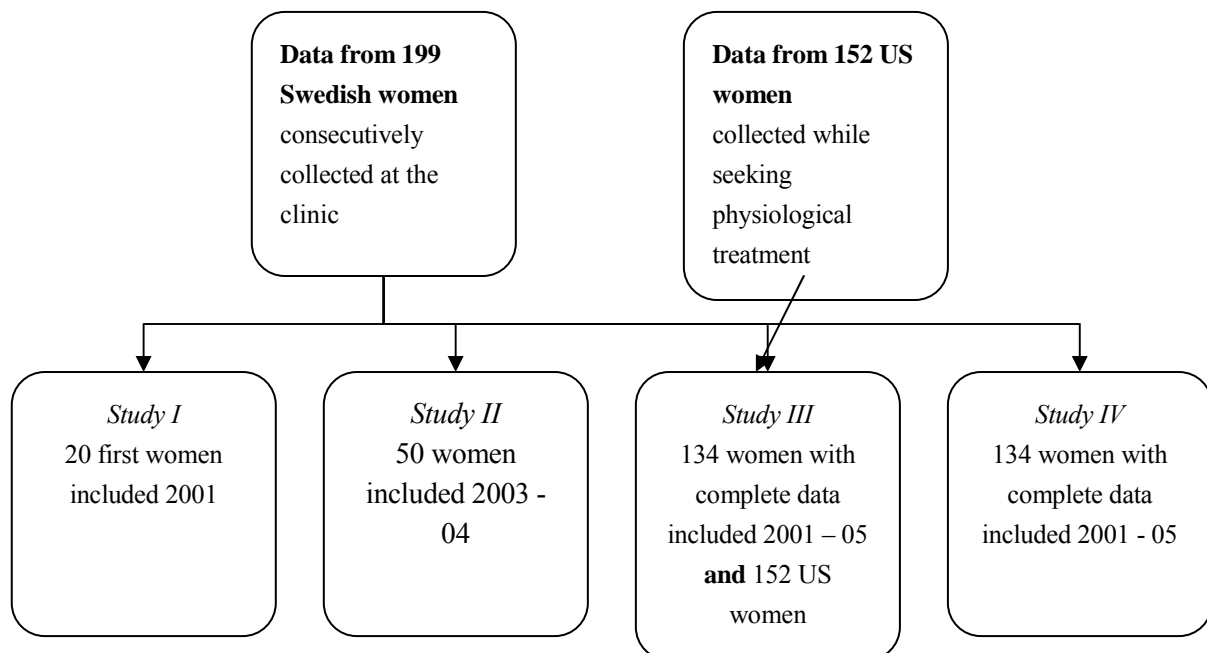


Figure 1. Overview of subjects in the thesis' studies.

3.2.1 The Swedish sample

Sample 1 was used in study I, II, III and IV. The women were voluntarily seeking treatment at the clinic, and consecutively included in the study during 2001 – 2005. All women received long-term treatment and had the possibility to tailor their own treatment drawing from a number of optional methods.

Data from 199 women were collected. Culturally, the group was relatively homogenous, with 85% being of ethnic Swedish background, 10% from other Scandinavian countries and 5% from other parts of Europe. Their lives reflected the expected participation patterns found in the Swedish society in that they were working and had family responsibilities. Their coming to the clinic was mainly through self-referral (71,6%) and referral from a general practitioner or through a company health service (28,4%). Further, sample characteristics from the 199 subjects showed that all of them had a stable housing situation, about 75% had custody for at least one child under 18 years (72%), and of those women 63% had more than one child. The mean ages of the children were 11.0 years (SD = 4.76). How well known the women's drinking problem was in the family was that 93 (46.7%) of them considered that the whole family was aware of the problem. However, more than half of them (53.3%) had the position that their partner was not aware of their drinking problem. Despite that they estimated the seriousness of their problem on a visual analogue scale (0 – 100, 0 = no problem; 100 = very big problem) to average 68.1 (SD 21.4)

The first 20 women constituted a pilot group (study I), entering treatment during the first half of 2001. Thirteen of these women had complete data and were also included in study III and IV.

From March 2003 to September 2004 the women entering treatment were interviewed about a typical drinking occasion (study II). From 105 women, 50 women were included in the study. Exclusion criteria were: being too psychologically fragile at the moment (n = 20), having language problems with communication in Swedish (n = 1), medical examination and consulting services only (n = 8), and treatment termination or interruption of treatment before planned interview (n = 26). Of these women 35 had complete data and were also included in study III and IV.

In study III and IV complete data sets from 134 women were used encompassing data from baseline through to the end of treatment. The average age for the 134 women in sample 1 was 42 years (SD = 7.1, range 22 – 55). Most women satisfied current DSM-IV criteria for alcohol dependence (n = 116, 86%) or alcohol abuse (n = 18, 14%). Excluded women, 65 (33%) had an average age of 40.2 (SD = 7.3, range 21 – 57), and had terminated their treatment for different kinds of reasons: interrupted treatment with a number of no shows, need for more intensive treatment, or moved to another city.

3.2.2 The US sample

Sample 2 was used in study III and consisted of 152 women drawn from a larger study of 511 women with risk-drinking patterns and medical conditions exacerbated by excessive alcohol use. The women were identified as drinking alcohol over the sensible

limits as they sought medical treatment at outpatient clinics in the US. The women included in sample 2 were randomized to receive a one-session brief intervention (BI) with follow-up, and were either T-ACE alcohol screen positive or drinking in excess of the sensible drinking limits for women (>7 drinks per week or > 1 drink/episode if younger than 65 years of age). The inclusion criteria included: (i) confirmed diagnosis of hypertension, diabetes, osteoporosis, or infertility; (ii) sufficient English to complete study measures and the interview; (iii) no current alcohol or substance abuse treatment; (iv) no current abuse of or dependence on opiates, cocaine, or other illicit substances; and, (v) not currently pregnant or breastfeeding. Their medical problems included hypertension (34%), diabetes (23%), osteoporosis (18%) and infertility (25%). The average age in sample 2 was 46 years (SD = 11.2, range 23 – 68). Among the women 30 (20%) satisfied criteria for current alcohol dependence and 111 (73%) exceeded sensible weekly drinking limits. Eleven women (7%) were alcohol screen positive only, yet had lifetime alcohol use disorders by history.

3.3 PROCEDURE

3.3.1 The Swedish sample

For all studies, both written and oral forms of information about the purpose and procedure of the study were presented to the patient at the second visit at the clinic. The potential participants were informed that not participating in the study would not influence their treatment quality. Oral consent to participate in the study was provided by each participant in accordance with ethical praxis. The inventories were distributed by the staff and completed at the same visit by the patient. A feedback-session based on the inventories (in study II including the interview) was provided to the women as a part of the treatment process. For study II the women were interviewed at a session between the third and the fifth visits. At the second to the last visit the follow-up inventories were distributed and completed as above.

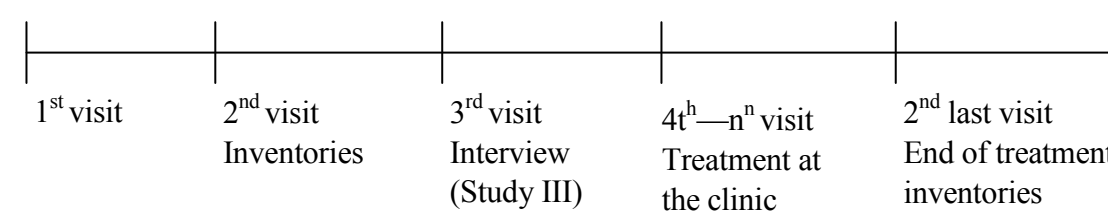


Figure 2. Time-line for the Swedish study sample.

3.3.2 The US sample

The US women were recruited for the study while in outpatient treatment for their respective primary medical condition. The women were invited by their physicians and the US research-group leader to participate in a study of women’s health habits. They

completed a screening questionnaire and, if they expressed interest in participating in the study, were assessed for eligibility criteria. The initial comprehensive assessment and Brief Intervention (BI) were both conducted in person; the follow-up interviews took place by telephone. All participants provided oral and written informed consent. All participants in this sample were randomized by computer to assessment followed by BI. They completed the measures and then met with one member of the study team trained to offer BI. The BI consisted of the standard core components: assessment and feedback, goal setting and contracting, behavioural modification, and written materials for review and reflection. The US women were then contacted by the staff for follow-up (FU) at 3-, 6- and 12 month checkpoints.

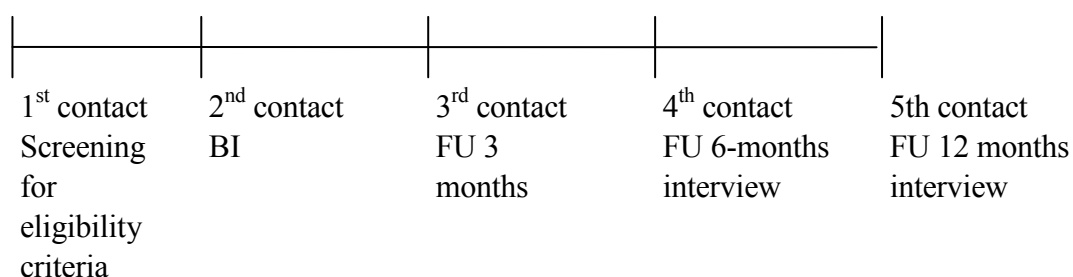


Figure 3. Time-line for the US study sample.

3.4 ETHICAL APPROVAL

The included studies were approved respectively by the Regional Ethics Board in Stockholm, Sweden (Dnr. 2006/876-31); and the Partners Institutional Review Board, Boston, US (2004-p-00687).

3.5 MEASURES

In the studies both written and oral types of data were collected. All data-collecting instruments are presented in Table 2. For a comparison of the instruments used in study III, see Table 3.

3.5.1 Inventories at baseline

The following inventories were completed at baseline.

The Alcohol Use Inventory (AVI-R)

The AVI-R, (Berglund *et al.*, 1986) comprises 89 multiple-choice questions measuring different dimensions of drinking effects. The Swedish version of AVI-R comprises 18 primary scales (Loss of control, Abstinence symptoms, Hallucinations, Earlier treatment, Social complications, Decreased depression, Enhanced contact ability, Enhanced thinking ability, Shame, Aggressiveness, Spouse reactions, Drinking outside

home, Social drinking, Daily drinking, Drinking duration, Use of sedative, Earlier spouse problems, and Use of narcotics) and five summarizing scales (Alcohol dependence, Psychological benefits, Complications of relations, Social drinking, and Daily drinking). AVI-R includes a self-report measure of *alcohol consumption* during a typical drinking week. The Swedish norms are based on male- and female alcoholics receiving treatment in Sweden. This inventory was completed by the Swedish women and data gathered were used in studies II, III and IV.

The Swedish Universities Scales of Personality (SSP)

A revised and reduced version (Gustavsson *et al.*, 2000) of the Karolinska Scales of Personality (KSP) (Schalling *et al.*, 1987), the SSP measure personality traits with 91 multiple-choice questions, giving different aspects of the personality in 13 different scales: Somatic trait anxiety (autonomic disturbances, restless, tense), Psychic trait anxiety (worrying, anticipating, lacking self-confidence), Stress susceptibility (easily fatigued, feeling uneasy when urged to speed up), Lack of assertiveness (lacks ability to speak up and/or be self-assertive in social situations), Impulsiveness (acting on the spur of the moment, non-planning), Adventure seeking (avoiding routine, need for change and action), Detachment (avoiding involvement in others, withdrawn), Social desirability, (socially conforming, friendly, helpful; reversed scale), Embitterment (unsatisfied, blaming and envying others), Trait Irritability (irritable, lacking patience), Mistrust (suspicious, distrusting people's motives), Verbal trait aggression (getting into arguments), and Physical trait aggression (getting into fights, hits back). Through factor analysis a three-factor solution corresponding to personality theories is used: Neuroticism, Aggressiveness, and Extraversion. This inventory was completed by the Swedish women and data gathered were used in studies II, III and IV.

The Health Index

This index is built on the Nottingham Health Profile (Andreasson *et al.*, 2002) and revised to Swedish conditions at the Karolinska Institute. It consists of twelve questions measuring self-perceived health during the preceding week, including areas of: psychic energy, mood, nervousness, loneliness, sleep, dizziness, stomach-problems, pain problems, health last week, and general health. A visual-analogue scale (0 – 100) is used where low values indicate poorer health. This index was completed by the Swedish women and data gathered were used in studies II and IV.

Intake form

The questionnaire extracted information about the women's current situation and motivation to change their drinking. Items used were: (i) their goal with treatment with 2 options: cut down and sobriety; (ii) their estimated degree of alcohol severity, presented in Visual Analogue Scale; and (iii) their motivation to change their drinking. This form was completed by the Swedish women and data generated were used in studies III and IV.

The Readiness to Change Questionnaire (RTCQ)

This is a 12-item questionnaire (Rollnick *et al.*, 1992), based on Prochaska's and DiClemente's stages of change model. The highest score along the continuum of change represents the subject's Stage of Change Designation derived through summing

items in each category. This questionnaire was completed by the US participants and data gathered were used in study III.

Perceived Stress Scale (PSS)

This scale (Cohen *et al.*, 1983) contains 14 items that intend to measure the degree to which situations in one's life are perceived as stressful. A mean score is calculated from a 5 degree scale from Never (0) to Very often (100). This form was completed by the US participants and data gathered were used in study III.

Structured Clinical Interview for DSM-IV

The module used was Substance Use Disorder Module (SCID) (First *et al.*, 1996). The interview is administered to generate current and lifetime alcohol and drug diagnoses according to criteria from the Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition (American Psychiatric Association, 1994). This interview was performed on the US participants and data gathered were used in study III.

The Consultation and Relational Empathy measure (CARE)

The scale (Mercer *et al.*, 2004) includes 10 statements about today's health care consultation each rated on a five degree scale, from Poor to Excellent. From this scale two items (statements 1 and 10) were used to ascertain the extent to which the participants perceived treatment respect from the staff and their rating of treatment satisfaction. This scale was completed by the US participants and data gathered were used in study III.

Time-line-follow-back (TLFB)

This instrument gave information about the participant's daily estimates of drinking (Sobell & Sobell, 1995). Information from TLFB was collected for the 6 months prior to study enrolment from the US participants and data gathered were used in study III.

3.5.2 Follow-up inventories

The following inventories were completed at the end of treatment or at follow-up.

Self-report measure of alcohol consumption already described.

Information was completed at the end of treatment by the Swedish women and data gathered were used in study II, III and IV.

The Health Index already described.

This index was completed at the end of the treatment period by the Swedish women and data gathered were used in studies II and IV.

Follow-up questionnaire

This instrument corresponds to the Intake form. The item used was: Your view on your future handling of your drinking problem (visual-analogue scale 0 – 100). Information from this questionnaire was completed at the end of treatment by the Swedish women and data gathered were used in study III and IV.

TLFB already described.

Information was collected from the US participants at the follow-up checkpoints and the data gathered were used in Study III.

3.5.3 Other instruments

Case journal

Information came from the Swedish women's case journals including material from the staff in the treatment team. Information included: collected demographic information, treatment notes, diagnostic notes, relapse information, process indicators, and social network information. This information was analyzed in study I.

Semi-structured interview

A semi-structured interview was used for the purpose of collecting information at the beginning of the treatment process. The interview is based on the personal, social and ecological model of culture and gender psychology and adapted to the Swedish context (DeMarinis *et al.*, 2009). The interview was conducted with the women by the Swedish treatment staff members between their 3rd – 5th appointments to the clinic. Data gathered were used in study II.

Data from *patients' medical records* and the local *patient registration system* (PVS) were used for additional information about occupational situation, earlier drug use, and psychiatric diagnoses according to DSM-IV diagnoses (American Psychiatric Association, 1994).

Table 2. Overview of instruments used in the different studies: the instrument, number of subjects for each instrument, when data was collected (collection phase) and in what study the collected data were used

<i>Instrument</i>	<i>Subjects</i>	<i>Collection phase</i>	<i>Study</i>
Case journal	20 Swedish	Baseline	I
Semi-structured Interview	50 Swedish	Baseline	II
Medical records	134 Swedish	Baseline, follow-up	II, III, IV
Alcohol Use Inventory, AVI-R	134 Swedish	Baseline	II, III, IV
AVI-R, self-report measure of alcohol consumption	134 Swedish	Baseline, follow-up	II, III, IV
Swedish Universities Scales of Personality, SSP	134 Swedish	Baseline	II, II, IV
The Health Index	134 Swedish	Baseline, follow-up	II, IV
Intake form	134 Swedish	Baseline	III, IV
Follow-up questionnaire	134 Swedish	Follow-up	III, IV
The Readiness To Change Questionnaire, RTCQ	152 US	Baseline	III
Perceived Stress Scale, PSS	152 US	Baseline	III
Structured Clinical Interview for DSM-IV	152 US	Baseline	III
The Consultation Relational and Empathy measure, CARE	152 US	Follow-up	III
Time-Line-Follow-Back, TLFB	152 US	Baseline, follow-up	III

Table 3. Comparison of instruments and items used in the Swedish and the US study-groups

<i>Variables</i>	<i>Swedish instruments</i>	<i>US instruments</i>
Attitude towards change (Swedish)/ Stage Designation (US)	<i>Intake form</i> <ol style="list-style-type: none"> 1. Subjects drinking goal: cut down, sobriety 2. How important is it for you to make an improvement of your drinking problem as a result of your treatment at the clinic (VAS) 3. Can you rate the degree of your alcohol problem? (VAS) (Attitude towards change: contemplation, action) 	<i>RTCQ</i> (Stage of Change Designation: precontemplation, contemplation, action)
Experienced stress	<i>SSP</i> Subscales for Psychic trait anxiety, Stress susceptibility, Embitterment, Irritability (T-scores)	<i>PSS</i> (Mean raw scores)
Treatment respect	<i>Follow-up questionnaire</i> <ol style="list-style-type: none"> 1. How satisfied are you with the respect from the staff at the clinic? 2. How satisfied are you with the treatment at the clinic? 	<i>CARE</i> (statements about today's consultation) <ol style="list-style-type: none"> 1. Making you feel at ease
Treatment satisfaction		<ol style="list-style-type: none"> 2. Making a plan of action with you
Gram alcohol	<i>Self-reported drinking of gram alcohol</i> a typical drinking week (gram)	<i>TLFB</i> (Daily report of consumed drinks) (gram)

Note. RTCQ = Readiness To Change Questionnaire, SSP = Swedish Universities Scales of Personality, PSS = Perceived Stress Scale, CARE = The consultation and relational empathy measure, TLFB = Time Line Follow-Back.

3.6 DATA ANALYSIS

3.6.1 Qualitative analyses

When analysing the text material in studies I and II, an established approach for qualitative research was undertaken (Malterud, 2001). This was done by first identifying units in the case journals/semi-structured interviews, then sorting information into variables and categories. A final procedure involved quantizing the data making statistically determined connections. A modified grounded theory approach (Strauss & Corbin, 1998) was used for the creation of new or refined themes. Two members of the research-team independently sorted and coded the qualitative data into each category/variable at each step of the process and an inter-rater comparison of this sorting process was conducted for satisfying the inter-rater agreement at an good to excellent level (Cicchetti, 1994).

3.6.1.1 Study I

An instrument for category formation was designed, informed by: (i) the Outline for Cultural Formulation (American Psychiatric Association, 2000; Group for the Advancement of Psychiatry, 2002), (ii) Kleinman's model of cultural dimensions (Kleinman, 1980), and (iii) case discussions with the staff at the clinic. This instrument resulted in six areas for identifying gender concerns in an alcohol treatment context for women in a Swedish cultural context. A seventh area summarized and analyzed the six areas with relation to clinical applicability, concluding that the cultural implications found in the study could inform the clinical process for women with alcohol problems in the Swedish society.

3.6.1.2 Study II

To explore the interview data and case journal material five different indices: parents drinking problem, perceived relation to father/mother, expectancies of change, and mood states were made based on the aims of the study. These indices were informed by theoretical perspectives from: (i) psychosocial alcohol theory (Marlatt & Gordon, 1985), (ii) attachment-theory (Bowlby, 1944; Daniel, 2006), (iii) coping strategies (Grusser *et al.*, 2007), and (iv) mood theory by Sjöberg (Sjöberg *et al.*, 1979). The data were entered into the Microsoft Access statistical database for analysis.

3.6.2 Quantitative analyses

In the *AVI-R* the results of the primary scale were divided in quartiles 1 – 4 (sorting the data into four equal parts, with each part representing 1/4th of the sample or population), and the summarizing scales were divided into deciles 1 – 10 (sorting the data into 10 equal parts, with each part representing 1/10th of the sample or population), and where higher quartiles/deciles indicate greater consequences caused by their drinking. Measures for alcohol consumption were calculated through gram alcohol per drinking day and percent drinking days at baseline and at the end of treatment/follow-up. Drinking change was measured by comparing baseline and follow-up grams of alcohol

per drinking day and percent drinking days. When analysing data from the personality instrument *SSP*, raw scores were transformed to gender- and age-related T-scores (mean norm: $T = 50$, $SD = 10$) according to Gustafsson et al. (Gustavsson *et al.*, 2000). In studies II and IV a hierarchical cluster analysis of personality and health variables indicating vulnerability was performed, using the default measure of distance (squared Euclidean) and the default clustering method (average linkage between groups). Statistical analyses for all quantitative data were performed in the Statistical Package for the Social Sciences (SPSS Inc., Chicago, IL, USA, version 15.0 and 17.0).

3.6.2.1 *Study II*

Descriptive statistics were calculated and inter-correlation between variables performed through Mann-Whitney *U*-test and Pearson's correlation coefficient. To describe the distribution of relations to parent characteristics over types of expectancy before drinking, an EXACON-method (Bergman & El-Khoury, 1987) was used.

3.6.2.2 *Study III*

Comparisons of Swedish and US instruments were performed through: (i) a linear transformation of VAS to a 5-categorical scale, and (ii) a split of VAS to a nominal scale. Pearson's correlation coefficient was calculated for inter-correlations between variables. The non-parametric Mann-Whitney rank sum and Spearman rank correlations test were used for not normally distributed data. To predict risk outcome a logistic regression analysis was performed with the results reported as odds ratios (OR) with 95% confidence Intervals (CI).

3.6.2.3 *Study IV*

Descriptive statistics were calculated and inter-correlations between variables performed through Pearson's correlation coefficient and Mann-Whitney *U*-test. Bonferroni corrections were used regarding *t*-test for equality of means.

4 RESULTS AND DISCUSSION

The following section contains a summary of the four studies included in the thesis. For a full presentation of the studies, see the original papers.

4.1 STUDY I

Cultural analysis as a perspective for gender-informed alcohol treatment research in a Swedish context

Aims

To investigate the role of cultural analysis for providing a gender-informed understanding of women's drinking and their self-referral to treatment at a clinic for women with alcohol problems in a Swedish treatment context.

Results

The findings of this qualitative study, based on exploration of data from the first 20 women consecutively seeking treatment at the clinic, resulted in an instrument for cultural analysis inquiry for identifying gender concerns in an alcohol treatment context for women. The instrument consisted of six primary question areas with the following results:

1. Is there a cultural identity status perceived by women in relation to their problem drinking?
 - A vast majority (90%) expressed their situation of having a drinking problem as one of being labelled first from the outside and eventually from the inside, and (75%) of the women expressed frustration over that the Swedish society still treats men and women differently concerning drinking problems. The perceived societal judgment contributed to feelings of shame and a quest for secrecy, contributing to the creation of a private drinking world
2. What are the perceived cultural explanations related to drinking and to problem drinking for women?
 - The majority (80%) had multiple explanations for their alcohol problems; (i) a medical explanation, (ii) a gender-specific social explanation, and (iii) blaming one's own shortcomings. This led to internal conflicts when forming an explanatory model
3. What are the culturally important factors relating to bio-psychosocial function for women in alcohol treatment?
 - The women had developed or experienced worsened somatisation patterns coupled with depression, anxiety, stress and other physical pain. They reported having problematic relationships, where 95% reported difficult experiences as children, including inadequate parenting, verbal, physical and/or sexual abuse, and having at least one parent with alcohol problems.

4. Are there cultural drinking patterns or ritual drinking behaviours that have a special meaning to women?
 - Their drinking patterns over time had followed a similar trajectory with experimental drinking and sub-group identity during early their teenage years. As drinking became more problematic and as life problems increased, social drinking rituals continued while private drinking rituals with special routines for drinking began
5. What are the perceived cultural means of relating between women and alcohol treatment caregivers and systems?
 - A majority (75%) had long standing patterns of healthcare utilization for both psychological and somatic conditions, where over 50% had been on sick leave in the past.
6. What are the cultural resources for recovery from/management of drinking problems?
 - A majority (85%) identified a need to grieve over the anticipated loss of alcohol and its different functions in their lives, and a need for re-ritualization (see theme 4) for replacing private ritual drinking.
7. Are there cultural implications that need to be incorporated in the gender-informed diagnosis and treatment planning for women?
 - The study concluded that the information provided in 1 – 6 contributed to a fuller understanding of how individual, societal and symbolic levels interact in the Swedish culture. Specific suggestions relating to approaching diagnosis and planning treatment interventions and strategies emerged.

Discussion

The study's findings support the idea of culturally influenced drinking typologies by Room and Mäkelä (Room & Makela, 2000) providing specific information on women's private drinking patterns. In agreement with Lex (Lex, 1991), the women's patterns of alcohol use and drinking consequences were complex, involving issues of self-esteem, anxiety and depression (Kohn *et al.*, 2002). The study's findings support the idea that cultural analysis might be a useful research resource in the diagnostic and treatment planning processes (Schmidt & Room, 1999; Kirmayer, 2006). A limitation in this study is that the results only can be attributed to a specific outpatient group at a women's treatment clinic in a specific cultural healthcare context. However, the findings support the idea that qualitative methods are useful for gaining new and more nuanced information about a group that perceives itself as stigmatized by society (Ames *et al.*, 1996).

4.2 STUDY II

Moods and expectancies of female alcohol drinking – an exploratory study

Aims

The overall objective of this study was to explore the expectancies of intoxication as related to individual differences concerning history of parental alcohol abuse and aspects of personality among women with alcohol problems. Specific aims were: (i) to explore possible relationships between self-reported moods and expectations of change before a typical drinking occasion vs. relationships with parents and treatment outcome in terms of alcohol consumption, and (ii) to investigate whether individual vulnerability factors in terms of personality and psychological health are related to severity of alcohol problems.

Results

The results are presented below for the study performed on data from 50 women seeking treatment on the clinic.

Moods and expectancies

Expressed *moods* before a typical drinking occasion were mostly negative feelings with *unpleasantness* (51%) as the most common mood, described as “irritated, worried, sad, depressed, and/or pessimistic”. Of the 50 women 30% described only a positive feeling before a typical drinking occasion; the rest described only negative moods or blended mood states. Expressed *expectancies* of what changes drinking alcohol would bring, were evenly divided among the alternatives: *reducing feeling*; *enhancing feeling*; or, *flight from feeling*.

Parents

Nearly half of the women expressed a negative relationship to mother (42%), to father (40%) and to both parents (22%). Positive relations to parents were reported by 12% of the women. A vast majority of the total study group had one or both parents with alcohol problems (82%). There was a significant correlation between a negative relation to mother and having both parents with alcohol problems ($r = 0.31$; $p < 0.05$). Analysis by Mann-Whitney *U*-test revealed that the women characterized by a self-reported positive relation to mother and having an expectancy of flight before drinking had significantly higher scores on psychic (cognitive-social) anxiety ($p < 0.009$), as compared to the other women.

Drinking outcomes

The women reduced their drinking when comparing gram alcohol consumption during a typical drinking week at the start and the end of treatment ($p < 0.0001$). It was found that a negative relation to mother was significantly related to a higher level of gram alcohol consumption at the end of treatment ($r = 0.363$; $p < 0.05$). In AVI-R, it was found that the women had more severe consequences of drinking in all of the summarizing scales as compared to alcoholics in general.

Personality, psychological health and patterns of vulnerability

Personality *SSP* trait data indicated that the study's women differed significantly from a standardized female population (Gustavsson *et al.*, 2000) regarding both somatic and cognitive-social anxiety, stress susceptibility, embitterment and irritability traits. Results from the *Health Index* showed that self-perceived psychological health (psychic energy, mood, nervousness, loneliness) at the start of treatment was poor among the women in the study. A hierarchical cluster analysis was performed including the above variables from *SSP* and the *Health Index*. The analysis resulted in two clusters (Cluster 1, $n = 25$; and Cluster 2, $n = 24$) and a residue of one patient. Differences between clusters showed that Cluster 1 had a slightly younger population ($p = 0.14$) and constituted a more burdened group with both poorer self-rated psychological health and physiological health as compared to Cluster 2 (all $p < 0.001$). The two clusters also differed in their mean personality profiles where the women in Cluster 1 had significantly higher scores on the anxiety-related scales than the ones in Cluster 2.

Discussion

The study provided support for our research hypotheses of possible associations of variables (i) Relations to parents and (ii) Expectations of change by drinking before a typical drinking occasion. Relations were found between a perceived positive relation to mother and an expectancy of flight before a typical drinking occasion, and between a perceived negative relation to mother and a negative treatment outcome. A majority of the women in this study spent their childhood with one or both parents suffering from alcohol problems and with a resulting increased probability of experienced negligence and/or trauma experience. The results showed that most of the women had a well-practised drinking pattern, drinking alone and with associated moods and expectancies of change in mood by drinking. Among the women in this study we could confirm two clusters based on a cluster analysis of personality and health variables indicating a vulnerability to psychiatric disturbances.

4.3 STUDY III

Treatment outcomes for risk drinking women: Brief and long term approaches

Aims

The purpose of this study was to contrast treatment approaches and outcomes for two samples of problem drinking women.

Results

The two samples consisted of: (i) 134 alcohol treatment-seeking women at a specialised clinic in Sweden who had received long-term treatment, and (ii) 152 US women seeking treatment for one of four medical conditions exacerbated by alcohol, who were provided a brief intervention (BI) treatment. Characteristics of the women revealed that the average age in the Swedish study-group was 42 years ($SD = 7.1$, range 22 – 55) and 46 years ($SD = 11.2$, range 23 – 68) in the US study-group. In the Swedish study-group most women satisfied current DSM-IV criteria for alcohol dependence (86%) or alcohol abuse (14%). Among the US sample subjects, 20% satisfied criteria for current

alcohol dependence and 73% exceeded sensible weekly drinking limits, drinking more than five standard drinks of alcohol per week.

Alcohol consumption

Gram alcohol and number of standard drinks (1 drink = 14 gram) per drinking week were calculated for both study-groups at the start and the end of treatment (Swedish study-group) or at the one year follow-up (the US study-group). Both samples reduced their drinking after having received treatment, though the decrease was larger for the Swedish women, who had been drinking larger amounts and having a higher percent of drinking days before treatment.

Table 4. Change in gram alcohol per drinking day; and change percent drinking days (from baseline consumption to the end of treatment/follow-up for the Swedish and the US women), and *t*-tests of change differences within study-groups

			N	M decrease	SD	One-sample <i>t</i> -test within study- groups
Information at a. End of treatment prior 12 months (Swedish) b. Follow-up prior 12 months (US)	Gram-change per drinking day	Sweden	134	45.00	59.39	8.77**
		US	144	4.19	24.87	2.02*
	Percent change in drinking days	Sweden	134	0.33	0.030	12.52**
		US	143 ^a	0.07	0.23	3.37**

Note. ** $p < 0.001$, * $p < 0.05$; ^a = 1 missing in the US study group

Attitudes towards change/Stage of Change Designation

Variables related to a change in alcohol consumption were attitude towards change for the Swedish women where the women who had abstinence as an initial treatment goal were more successful in cutting down their drinking to a non risky level at end of treatment as compared to the women with the goal of “cutting down” their drinking ($r = 0.17$; $p < 0.05$). For the US women a Stage of Change classification showed that the women in the “contemplation stage” (have contemplated over their drinking being a problem) at the start of treatment were nearly three times more likely (OR 2.89, 95% CI: 1.07-7.79) to continue drinking at a risky level at follow-up compared to those in the “precontemplation stage” (never contemplated over their drinking being a problem) or “action stage” (ready to try to change their drinking).

Perceived stress

Results of perceived stress measured by SSP in the Swedish study-group showed that women displayed scale score close to the mean norm in Psychic trait anxiety, and about 0.5 SD above the mean norm in Stress susceptibility, Irritability, and Embitterment. Results indicated that women with 1 SD or more above the mean norm in Embitterment were more prone to have a treatment goal to “quit drinking” ($\rho = 0.182, p < 0.05$) and to have been drinking more alcohol than the other women at the start of treatment (Mann-Whitney test: $z = -3.389, p < 0.001$). The US women as a group experienced normal psychic stress, having mean raw scores close to female mean norm PSS scores. The women with PSS-scores exceeding 1 SD above the mean norm were drinking more alcohol than the other women at the start of treatment (Mann-Whitney test: $z = 3.036, p = 0.02$), however there were no differences in alcohol consumption at the follow-up.

Experiences of treatment

Subjects in both the Swedish and US study groups were very satisfied with particular aspects of treatment, and there were significant correlations between a decrease in percent drinking days at the end of treatment and treatment satisfaction ($r = -0.31, p \leq 0.01$) versus treatment respect (the women’s perceived attitude from staff) ($r = -0.22, p \leq 0.05$) among the Swedish women, showing that the women who were most successful in cutting down their drinking also rated treatment most empowering. Further, a significant relation was found showing that the Swedish women with high values in treatment satisfaction were more likely to maintain drinking below the risk limit ($t = 3.253, p < 0.001$)

Discussion

This descriptive study compared two groups of women with drinking problems who received two different treatment approaches, each highlighting the options available. The main finding is that both groups of women demonstrated a decrease in alcohol consumption, as measured by grams per drinking day and percent drinking days. All women drank in excess of recommended guidelines; however the Swedish women drank considerably more per day. Interesting similarities between the groups were shown, despite the marked differences in length of treatment as well as different cultural contexts and healthcare systems. First, the women’s attitude to changing their drinking was important. Specifically, the Swedish women who selected abstinence as their goal were more likely to reduce their drinking. Among the US women, those in the “contemplation” stage of change were the least likely to reduce their alcohol use. Second, the women’s perception of treatment is an important factor for success. Third, the women’s experience of stress may play a role in the amount of consumed alcohol. Thus, highly stressed women could be a particular risk group of women who are vulnerable to developing alcohol problems.

4.4 STUDY IV

Women with alcohol problems – the possible significance of personality clustering for treatment planning

Aims

The purpose with the present study was to establish possible differences in treatment outcome in terms of: (1) drinking outcomes (gram and number of drinking days); (2) perceived physiological health; and, use of treatment resources (length of time in treatment and number of visits) through an analysis of the data of 134 consecutive, treatment-seeking women with alcohol problems in a clinical context, based upon previously identified personality and psychological health clusters.

Results

Personality and health variables

A hierarchical cluster analysis was performed including: (i) Variables of psychological health from the Health Index, in which the total sample had a mean score for each variable below the mean norm (psychic energy, mood, nervousness, loneliness); and (ii) SSP personality scales, in which the total sample differed significantly from a female norm population (Somatic trait anxiety, Psychic trait anxiety, Stress susceptibility, Embitterment, Mistrust). The analysis resulted in two clusters (Cluster 1, $n = 53$; and Cluster 2, $n = 80$) with a residue of one patient, see Figures 4 and 5.

Further analyses of personality traits showed that the women in Cluster 1 were psychologically more vulnerable compared to the women in Cluster 2, in that they were less self-assertive (Lack of assertiveness, $p < 0.01$), more withdrawn (Detachment, $p = 0.019$), and more irritable (Trait irritability, $p < 0.01$).

The self-rated over-all health (including both psychological and physiological health) at the start of treatment was different for the women in the clusters. Those in Cluster 1 having a lower over-all health status ($M = 45.6$, $SD = 27.8$) as compared to the women in Cluster 2 ($M = 75.1$, $SD = 26$), $p = 0.004$. Furthermore, those in Cluster 1 rated their problems with dizziness worse ($M = 70.0$, $SD = 26.5$) than those in Cluster 2 ($M = 82.8$, $SD = 23.2$), $p < 0.0001$.

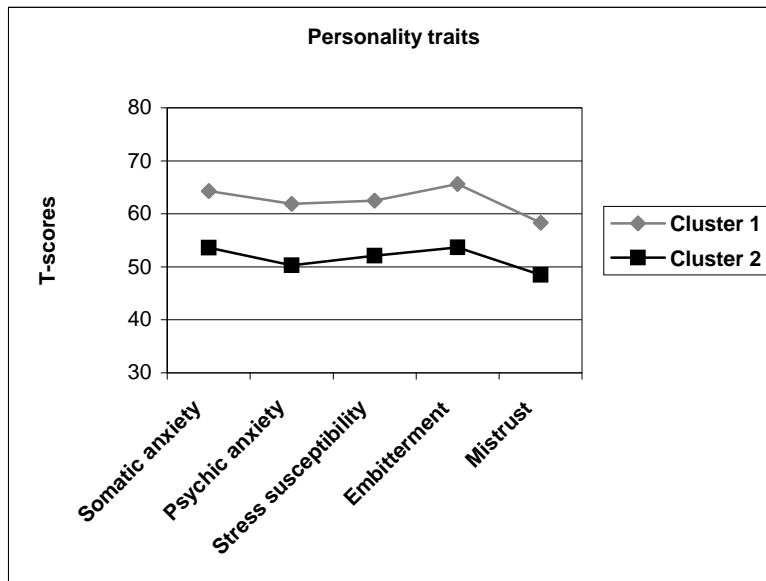


Figure 4. Self-rated personality traits at the start of treatment for female patients with alcohol problems, Cluster 1 (n = 53) and Cluster 2 (n = 80), where T = 50, SD = 10.

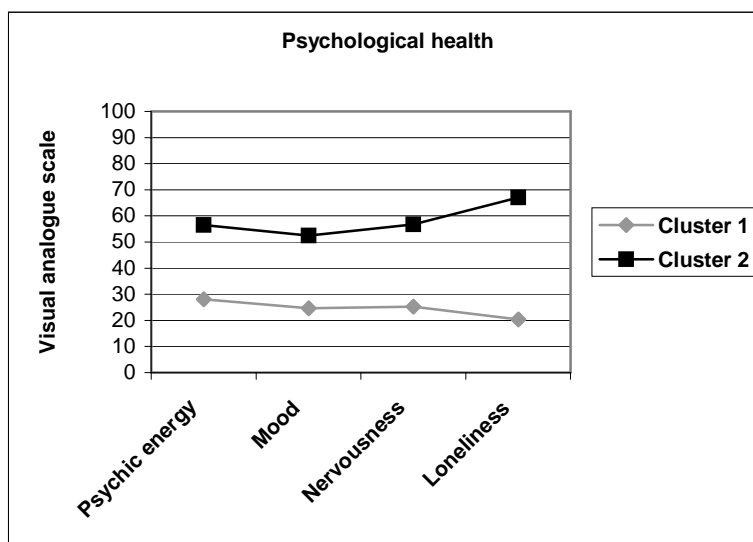


Figure 5. Self-rated psychological health at the start of treatment for female patients with alcohol problems. Cluster 1 (n = 53) and Cluster 2 (n = 80), presented in visual analogue scales (0 – 100) where low values indicates worse health.

Alcohol consumption and consequences

The consumption of alcohol was rather similar between the women in the two clusters, both at baseline (M = 90.1, SD = 43.5) and at the end of treatment (M = 45.2, SD = 49.0). No significant differences were found in the percent of drinking days at baseline (M = 0.36, SD = 0.29) or at the end of treatment (M = 0.14, SD = 0.20). The mean number of years the women reported that they had been drinking in this way was equal for the women in the clusters, about four and a half years.

All results were in favour of the women in Cluster 2 having fewer consequences as a result of drinking. Likewise, self-reported consequences of drinking in the AVI-R showed similar differences between the clusters in the primary scales of Decreased depression ($p = 0.001$), Enhanced contact ability ($p = 0.006$), Enhanced thinking ability ($p = 0.03$), and Earlier family problems due to alcohol consumption ($p = 0.022$).

Treatment utilization

In total, the women in Cluster 1 visited the clinic more times ($M = 80.3$, $SD = 8.1$) compared to the women in Cluster 2 ($M = 56.6$, $SD = 4.2$), indicating a significant difference between the clusters ($t = 2.84$, $p = 0.005$). The women in Cluster 1 stayed in treatment with a mean of 744.0 days as compared to the women in Cluster 2 with a mean of 622.5 days; however, there was no significant difference observed. Observing the number of cancellations, the women in Cluster 1 had more cancellations as compared to those in Cluster 2 ($t = 2.18$, $p = 0.031$).

At the end of treatment

At the end of the treatment the women in Cluster 1 still rated their health worse than those in Cluster 2, regarding most scales in the Health Index. The women in Cluster 1 were slightly less hopeful regarding their future handling of drinking ($p = 0.065$) than were Cluster 2 women.

Discussion

The main finding in this study was that two different clusters of treatment-seeking women were found. On the basis of scale-score in personality traits, and self-rated psychological health variables, two clusters of women were identified. Those in the first cluster (Cluster 1) had personality traits above the norm mean, and below satisfying self-rated psychological health. The women in Cluster 2 experienced normal health in the clustering variables. Enhanced values in the personality traits included in the cluster analysis could contribute to daily life problems. Furthermore, the women in Cluster 1 had worse physiological health than those in Cluster 2, both at the start and after treatment.

The consumption of alcohol was similar between the women in the two clusters, both at the start and at the end of treatment. Yet, the self-reported consequences were far more pronounced for the women in Cluster 1 as compared to those in Cluster 2. The women in Cluster 1 needed far more time in treatment to enhance a decrease in drinking that was compatible with the women in Cluster 2.

5 GENERAL DISCUSSION

The work in this thesis has focused on treatment-seeking women with alcohol problems. The main aims were to explore the women's underlying individual and psychosocial characteristics within a Swedish context, and to examine factors influencing treatment outcomes. This thesis was approached with an understanding of the development of alcohol problems as a complex interaction between several factors. The interactional perspective applied here suggests that the development of alcohol problems can depend on several factors, and their interaction, both from within the individual as well as from the immediate and extended psychosocial environment. Furthermore, an interactional perspective assumes that all individuals do not develop in the same way, as there is individual variation in development. Hence, a person-oriented method, creating an individual's profile, may be a valuable supplement to other methods in this area (Bergman & Magnusson, 1997).

Of special interest in this thesis are the factors that reflect individual differences and their implications for psychological and physiological health. Exploring a group of alcohol-treatment-seeking women from this starting point can provide valuable knowledge of how individual differences are mirrored in the development of alcohol problems, and can identify possible new directions for treatment planning.

5.1 MAIN FINDINGS

Understanding the cultural context in which the individual is acting can contribute to understanding the drinking patterns and approach to treatment among women. From this vantage point the results of perceived societal judgment found among the Swedish treatment-seeking women with alcohol problems strengthen the importance of taking cultural messages into consideration. This is of particular importance when interpreting the underlying psychosocial characteristics for the women of this study (DeMarinis *et al.*, 2009). Also Mäkelä *et al.* (Makela *et al.*, 2006) found clear gender differences in a study of European drinking cultures. In societies where drinking is surrounded by ideas about femininity/ masculinity, female alcohol drinking is often connected to feelings of guilt and shame over not being 'correctly' feminine and may be a hindering factor for seeking treatment (Kearney, 1997; Jakobsson *et al.*, 2008). A hypothesis generated through this study of interest for further investigation is that Swedish women seem to prefer a women-only treatment when optional (Dahlgren & Willander, 1989; DeMarinis *et al.*, 2009). It therefore seems of great importance to offer women-only treatment in the Swedish context, or of having the possibility to address explicitly the particular needs of treatment-seeking women in a mixed-sex treatment facility.

Well established drinking patterns were found in this group of treatment-seeking Swedish women with alcohol problems. This was expressed in that most women were qualified for the diagnoses of alcohol dependence, and that they could identify a set of specific behaviours surrounding a typical drinking occasion (drinking ritual). The typical drinking occasion was manifested by drinking alone and by having expectancies of change in mood by drinking (DeMarinis *et al.*, 2009; Scheffel-Birath *et al.*, 2009a). The women in general had a daily alcohol consumption corresponding to one bottle of

wine, seven days per week (Scheffel-Birath *et al.*, 2009a; Scheffel-Birath *et al.*, 2009b; Scheffel-Birath *et al.*, 2009c).

Despite this, the women were still functioning relatively-well socially, and most probably this cost a great deal of strain to maintain. Having developed an alcohol dependence in combination with a personality disorder is known to be difficult to treat (Fridell *et al.*, 2006). If women with such heavy alcohol consumption are not offered attractive treatment options at an early stage there is probably at great risk for even more serious consequences of their drinking. However, having treatment resulted in a significant decrease of alcohol, either having access to long term or short treatment (DeMarinis *et al.*, 2009; Scheffel-Birath *et al.*, 2009a; Scheffel-Birath *et al.*, 2009b; Scheffel-Birath *et al.*, 2009c).

Several factors were influencing treatment outcome. The most important factor seems to be the possibility of being offered any type of alcohol treatment. It was shown that both the US women treated by BI and the Swedish women that had long-term treatment did equally well in decreasing their drinking. Further, it was shown that treatment-seeking women in long-term services used the treatment to different extents. The more psychologically healthy women reached the same decrease in drinking with a significantly lower number of times in treatment as compared to the women with worse psychological health. This could indicate that short term treatment could be enough for women with risk drinking, women who are not actively treatment-seeking, or even for women with a more severe alcohol problem yet having relatively good psychological health. For women seeking treatment for alcohol dependence diagnoses and experiencing strained psychological health, it is important to have the opportunity for long-term, gender-informed treatment service as well as the possibility to influence the treatment process.

The treatment-seeking group of women studied was shown to be a heterogenic group with respect to their personality profiles and perceived psychological health. One of the most striking results from the studies is that almost half of the Swedish treatment-seeking women suffered from impaired psychological health and personality traits deviant from the mean norm (Scheffel-Birath *et al.*, 2009a; Scheffel-Birath *et al.*, 2009c). As the concept of personality could be described as partly grounded in genetic dispositions that could be reinforced or not developed during the lifespan, these women's problems can be a result of strains during their childhood (Watson *et al.*, 1994; Spak *et al.*, 1997). Most of the Swedish women in these studies were raised with one or both parents/stepparent having alcohol problems, and experiencing a negative relation to one or both parents. Being exposed to a family environment where alcohol frequently was used, as these women were, could bring with it an increased probability of experienced negligence or trauma. The experienced negative relation to parents is possibly linked to these experienced traumatic situations, and connected to the parents' drinking problems during the women's childhood. Together with an increased vulnerability for psychological distress, being exposed to abuse as a child would probably mean that this group of women had an increased risk for developing alcohol and/or other psychiatric problems, as well as more difficulties when coping with daily life situations and addressing problems. This group of women, it can be concluded, therefore needs longer treatment and accesses to diversified resources during treatment.

The healthier group of women in the studies generally had experienced the same extent of parental drinking during childhood. However, this group had a more positive attitude to receiving help and needed fewer times in treatment to achieve the same level of non-risky drinking as did the more psychologically burdened group. This brings up the issue of how long and intensive treatment should be to address these more or less healthy groups of women. This links to a new area of treatment research that has been generally focused on matching individuals to different treatment methods (Project Match Research Group, 1998; Read *et al.*, 2001; Miller & Wilbourne, 2002; Kaner *et al.*, 2007).

5.2 METHODOLOGICAL CONSIDERATIONS

The overall limitation in the studies included in this thesis is that the Swedish data were collected from a selected group of treatment-seeking women with alcohol problems. The studies were performed at a clinic in a larger city in Sweden, and no control group was used. These facts limit the possibility to generalize the results to a larger population of women with alcohol problems.

From the whole population of 199 women we managed to collect complete data from 134 (67%) women. This may weaken the possibility to generalize to the whole population of treatment-seeking women with alcohol problems. However, there were no differences found between the women with complete data and incomplete data at baseline. Further investigation of the factors that contributed to the 33% of the women that chose to interrupt their treatment or to not answer the follow-up questionnaires would be important.

The sample sizes in study I and II were rather small and could affect the validity of results. In study I data collection and data analyses were performed within the parameters of a qualitative study protocol and thereby meeting the validity criteria of such. In qualitative analyses the work with validity and reliability is continual during both data collection, analyses and presentation of results (Tashakkori & Teddlie, 2003). In study II the statistical analyses were mainly performed on a qualitative data set where small populations usually are accepted. The data set was then converted and quantitized into indices in accordance with established procedure (Tashakkori & Teddlie, 2003).

The data collected from case journals, mainly used in study I, represent reflections and notations from clinicians, and no stringent way of writing down this information was established at the time for data collection to study I. However, as an effect of the findings in study I a template for recording case journal information was introduced.

Regarding study III there is a potential limitation regarding the included samples. The two study samples used were not directly comparable, where the samples consisted of (i) treatment seeking Swedish women for alcohol problems, and (ii) treatment seeking US women for medical problems, and having concurrent alcohol problems. The data from the two very different samples were not compared in the study, but rather

contrasted in order to problematize a number of different factors involved for examining the effects of different treatment methods on women with alcohol problems. A more optimal design would have been a more standard comparison of treatment options using comparable samples. Most optimal would certainly have been a randomized controlled trial (RCT) design if such would be possible, but performing such a study was outside the limits of this doctoral work. If one were to pursue such an RTC, both personality and health factors would need to be considered in the planning of the design. With these limitations well in mind, this study could be used as a pilot study for a closer investigation of the optimal number of times needed in treatment for women with different degrees of alcohol problems.

The instrument used for data about perceived psychological and physiological health is a health questionnaire, the Health Index. This index is influenced by instruments that have been tested for validity and reliability, but in its present form it has not been tested nor used in any other study. However, when comparing data from the Health Index and SSP in studies II and IV, congruence between these instruments was found that can be interpreted as a validation of the Health Index.

5.3 CONCLUSIONS

The Swedish women included in this thesis were all treatment seeking at a clinic specialized for women with alcohol problems. They were all in need of help for addressing their developed alcohol dependence diagnoses. Despite drinking an average of one bottle of wine per day they still had a stable living situation, custody over their children, and a connection to the labour market (at work or on paid sick-leave). Maintaining function in these areas while at the same time consuming this degree of alcohol made many demands on their activity planning, time, and energy.

This group of treatment-seeking women for their alcohol problems was heterogenic. Two groups were found, with one group being relatively stable in personality and in perceived psychological health, and the other having personality traits above the norm mean indicating experiences of anxiety, stress susceptibility, and embitterment, as well as a less satisfying perceived psychological health. Both groups of women decreased their drinking significantly after the received treatment. However, the healthier group of women needed about half the treatment time that was required for the more burdened group of women in terms of arriving at the same level of non-risky drinking. This highlighted the importance of discussing length of treatment when planning treatment options.

Having the opportunity to receive treatment for alcohol problems is valuable. Most women included in this thesis could change their drinking habits after treatment to a non-risky drinking pattern irrespective of their different alcohol consumption levels before treatment.

5.4 FUTURE DIRECTIONS

Using a cultural perspective for creating an enhanced gender profile when investigating women with alcohol problems, has been useful for gaining an increased understanding of: drinking patterns, feelings connected to drinking, and approaching treatment outcomes. Applying a cultural perspective for a better understanding of gender-specific areas associated with men's drinking might also prove useful and might thereby enrich the treatment options for both men and women, and for planning related couple and family strategies.

Further studies on treatment planning and treatment methods for women with alcohol problems aimed at matching treatment time and resources to women's psychological health would show if time and cost could be decreased for women who were more psychologically healthy, and less vulnerable concerning personality and daily life behaviour. This however needs to be addressed in future research.

6 SVENSK POPULÄRVETENSKAPLIG SAMMANFATTNING

Riskfyllt drickande av alkohol är på flera sätt mer skadligt för kvinnor än för män. De fysiologiska konsekvenserna av drickandet kommer snabbare för kvinnor bland annat beroende på en till vissa delar olika ämnesomsättning samt att fördelningen vätska/fett i kroppen är annorlunda för kvinnor än vad man ser hos män. Till de allvarligare fysiologiska konsekvenserna för kvinnor av alkoholförtäring hör bland annat olika cancerformer (till exempel bröstcancer och strupcancer), hjärt- och kärlsjukdomar och diabetes. De psykologiska konsekvenserna av drickande utgörs bland annat av en ökad risk för depression och självmord, vilket gäller både kvinnor och män. I takt med att kvinnors drickande har ökat, har även särskilda behandlingsalternativ för kvinnor etablerat sig. Svensk forskning har visat att kvinnor lyckades bättre i behandling om de får hjälp på en mottagning anpassad för kvinnor jämfört med om de får behandling på en mottagning som vänder sig till både män och kvinnor. Detta kan troligen ha berott på att behandling av alkoholproblem huvudsakligen var inriktad på den stora målgruppen för behandling, vilken tidigare utgjordes av män.

Avsikten med denna avhandling var att undersöka kvinnor som söker hjälp för sina alkoholproblem. Vi ville närmare studera underliggande individuella och psykosociala karaktäristika för kvinnorna i denna svenska grupp. Vi avsåg även att undersöka olika faktorer som kan påverka behandlingsutfall mätt i alkoholkonsumtion, nöjdhet med behandling samt upplevelse av stress i relation till alkoholkonsumtion för kvinnor i behandling för sina alkoholproblem.

I den första studien (Study I), en kvalitativ studie av de 20 första kvinnorna i kohorten, undersöktes journalanteckningar för att förklara hur kulturella faktorer påverkar kvinnors drickande i Sverige. Studien visade att kvinnorna kände sig stämplade på grund av sina alkoholproblem samt att de kände sig frustrerade över att de upplevde att samhället behandlar män och kvinnor med alkoholproblem på olika sätt. De flesta (95%) beskrev en problematisk uppväxt med upplevelser av misshandel förekom, såväl verbal, fysisk som sexuell. De flesta var också uppvuxna med minst en (1) förälder som hade missbruksproblem. Kvinnorna beskrev att deras eget drickande hade utvecklats sedan tonåren då de börjat experimentera med alkohol och sedan fortsatt med sitt drickande in i vuxenlivet. Vid studiens genomförande hade de utvecklat ett problematiskt drickande med både socialt drickande samt privat drickande i ensamhet.

Den andra studien (Study II) avsåg att undersöka det privata drickandet hos 50 kvinnor, dels avseende känslotillstånd och förväntningar på förändringar i känslotillstånden vid drickande, dels om deras upplevelse av relationen till föräldrarna påverkade behandlingsutfallet. I studien framkom att alla hade förväntningar på ett förändrat sinnestillstånd i samband med ett typiskt dryckestillfälle samt att det mestadels var negativa känslor som de avsåg att hantera med hjälp av alkoholen. Som grupp betraktat så minskade kvinnorna sitt drickande signifikant under behandlingen. Resultaten visade även att 82 % av kvinnorna var uppvuxna med alkoholproblem hos en eller båda föräldrarna. Endast 12 % tyckte att de hade en positiv relation till båda föräldrarna och det fanns ett statistiskt samband mellan att ha en negativ relation till sin mamma och

samtidigt ha två föräldrar med alkoholproblem. Det fanns även ett statistiskt samband mellan en upplevd negativ relation till mamman och ett relativt sämre behandlingsutfall än för övriga kvinnor.

I den tredje studien (Study III) undersöktes 134 svenska kvinnor som fick långtidsbehandling och 152 amerikanska kvinnor som fick en korttidsbehandling för sina alkoholproblem. Korttidsbehandlingen innebar att man endast fick några behandlingstillfällen som huvudsakligen fokuserades på att kartlägga drickandet, rådgivning om allvarlighetsgraden i drickandet, om hur man kan förändra sitt drickande samt hur man kan bli bättre på att uppnå resultat avseende minskat drickande. De svenska kvinnorna drack signifikant mycket mer före behandlingen jämfört med de amerikanska. Resultaten visade dock att båda grupperna av kvinnor minskade sitt drickande efter genomgången behandling både avseende gram alkohol/dryckesdag och procent dryckesdagar. Faktorer som påverkade behandlingsutfallet gynnsamt var för de svenska kvinnorna att ha som mål med behandlingen att bli nykter jämfört med att ”skära ned”, samt att vara nöjd med behandlingen. Framgångsfaktorer för de amerikanska kvinnorna var att antingen vara beredda på att förändra sitt drickande eller att inte ha reflekterat över att drickandet kunde innebära problem, samt att vara nöjd med behandlingen.

Den fjärde studien (Study IV) hade som syfte att undersöka om gruppen svenska kvinnor som frivilligt söker hjälp för sina alkoholproblem på en alkoholtvättning är en heterogen grupp avseende personlighetsdrag samt upplevd psykologisk hälsa. I studien undersöktes 134 kvinnor med hjälp av ett personlighetsformulär samt ett formulär för självskattad psykologisk och fysiologisk hälsa. Resultaten visade att gruppen kvinnor kunde delas in i två olika grupper (kluster). *Kluster 1* omfattade kvinnor som uppvisade personlighetsdrag (somatisk och psykisk ångest, stresskänslighet, bitterhet, misstro) som avvek signifikant från normalpopulationens medelvärden. De skattade även sin psykologiska hälsa under den senaste veckan (psykisk energi, sinnesstämning, nervositet, ensamhet) till en icke tillfredsställande nivå. *Kluster 2* omfattade kvinnor som uppvisade personlighetsdrag som inte avvek från normalpopulationens medelvärden: de skattade även sin psykologiska hälsa som relativt tillfredsställande. Kvinnorna i de båda klustren drack i genomsnitt samma mängd alkohol både vid behandlingens start och vid avslutning, dock behövde kvinnorna i Kluster 1 signifikant fler besök för att uppnå samma minskning som kvinnorna i Kluster 2.

Sammanfattningsvis så visar studierna i denna avhandling att kvinnor som söker hjälp för sina alkoholproblem är en grupp kvinnor med relativt sett allvarliga alkoholproblem då de utvecklat diagnosen alkoholberoende. Trots den höga konsumtionen av alkohol hade de ännu anknytning till arbetsmarknaden, bostad samt vårdnaden av minderåriga barn. Upprätthållandet av allt detta var troligen förenat med stora ansträngningar. Kvinnorna själva upplevde att de dessutom ansågs tillhöra en grupp med negativa förtecken i samhället och de kände skuld och skam över detta. Möjligheten att få behandling för sina alkoholproblem upplevde de som värdefull och merparten av kvinnorna minskade sitt drickande. De hade vid behandlingens slut antingen slutat dricka helt eller drack en mindre mängd alkohol, som kan anses riskfri avseende fysiologiska och psykologiska komplikationer.

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